STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,324
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Office of Vermont Health Access (OVHA) denying her prior approval for transportation services to go to doctor appointments in Boston and other out-of-state locations. The issue is whether the petitioner has cooperated in allowing the Department to contact her doctors to establish whether such services are medically necessary.

DISCUSSION

The petitioner was the subject of Fair Hearing No. 19,887. On November 4, 2005 the Board issued an Order in that matter, a copy of which is attached. Following that Order the Department informed the petitioner and the Board that it would no longer provide the petitioner with Medicaid transportation services to out-of state medical appointments due to the petitioner's refusal to allow the Department to contact any of her out-of-state medical providers to verify the need for such services.

In a telephone status conference held on February 27, 2006, and in several written communications with the Department and the Board, the petitioner confirmed that she was refusing to allow the Department to contact her medical providers, and that she was withdrawing all her pending hearings with the Board to pursue other legal remedies. Although the hearing officer and the Department advised otherwise, the petitioner was adamant in her desire not to pursue these matters before the Board. Pursuant to the petitioner's instructions, on March 8, 2006 the Board marked as "withdrawn" Fair Hearing Nos. 19,887, 20,026, and 20,063, which were pending at that time.

On May 9, 2006, the Board received a letter by fax from the petitioner requesting that the hearing officer "inform" the Department that it should reimburse her for accumulated expenses of "over $3,000" for transportation to medical appointments. The Board treated this letter as a new request for fair hearing.

During a phone status conference with the petitioner and the Department's attorney held on May 15, 2006 the petitioner adamantly stated her refusal to sign a release to allow the Department to contact any of her medical providers to verify that any of her claimed transportation expenses were

medically necessary. Other than asserting that the requirement that she sign such a release is "unjust" and "discrimination", the petitioner articulated no other basis or explanation for her refusal to cooperate in this regard.

ORDER

The Department's decision is affirmed.

REASONS

Medicaid Manual § M755 provides as follows:

Transportation

Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.

The following limitations on coverage shall apply

1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)

2. Transportation is not otherwise available to the Medicaid recipient.
3. Transportation is to and from necessary medical services.

4. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient’s freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient’s personal choice of provider.

5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.

6. Reimbursement for the service is limited to enrolled transportation providers.

7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.

8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

The regulations regarding prior approval include the following provision:

> The Department is responsible for determining questions of coverage and medical necessity under the Vermont Medicaid program. The department may contract with external organizations to help make these determinations: however, the final decision rests with the department.
>
> Supporting information for a prior authorization request must include a completed claim and a completed medical necessity form. Additional information that may be required includes:
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> - the patient's complete medical record;
> - the patient's plan of care;
> - a statement of long-term and short-term treatment goals;
> - a response to clinical questions posed by the department;
> - a second opinion or an evaluation by another practitioner, at Medicaid expense;
> - the practitioner's detailed and reasoned opinion in support of medical necessity;
> - a statement of the alternatives considered and the provider's reasons for rejecting them; and,

- a statement of the practitioner’s evaluation of alternatives suggested by the department and the providers reasons for rejecting them.

If any of this additional information is required, the department will notify the provider promptly. Once the necessary information has been received, the beneficiary will be sent a notice of decision that may be appealed. See M142.

In Fair Hearing No. 19,887 the Department agreed to provide the petitioner with medical transportation services while it attempted to verify the petitioner's medical need for such services.[1] When the Department subsequently discontinued coverage based on the petitioner's refusal to allow the Department access to her out-of-state providers and her medical records, the petitioner unilaterally withdrew that and other pending fair hearings before the Board could consider the issue. However, that same issue can now be considered.

Unfortunately for the petitioner, the above regulations are clear that she is required to cooperate in allowing the Department to verify the medical necessity of any item or

[1] The Department's agreement and the Board's Order were based on the hearing officer's conclusion and recommendation that the Department had impermissibly denied coverage for transportation services *prior to* a reasonable attempt to verify that such services were *not* medically necessary for the petitioner. However, nothing in the hearing officer's recommendation held or intimated that the petitioner was not required to cooperate in reasonable attempts by the Department to obtain pertinent medical information to verify the petitioner's need for any Medicaid service, including transportation.

service for which prior approval is necessary.[2] The regulations are also clear that medical transportation is such a service. The petitioner is certainly within her individual rights to refuse the Department, or anyone else, access to her medical records and providers. However, the Department is clearly within its rights and responsibilities in administering a costly public benefits program to condition coverage for benefits under that program on the cooperation of the recipient in furnishing basic and necessary information that bears directly on that recipient's eligibility. Unless and until the petitioner allows the Department a reasonable and meaningful way to verify her medical need for out-of-state medical treatment, under the above regulations the Department is not required to grant prior approval for her transportation costs in obtaining such services. Therefore, the Board is bound to affirm the Department's decision in this matter. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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[2] Similarly, the General Assistance regulations provide: "To be eligible for consideration for assistance, applicants must agree to the requisite investigation of their circumstances." W.A.M. § 2604.